Senate Budget & Fiscal Review

Subcommittee No. 3
on
Health, Human Services, Labor, and Veterans Affairs

Senator Wesley Chesbro, Chair
Senator Ray N. Haynes
Senator Deborah Ortiz

April 22, 2002
1:30 P.M.
ROOM 112

(Diane Van Maren, Consultant)

Item	***Description***
2400	**Department of Managed Care—Selected Issues**
0530	**Health and Human Services Agency—Selected Issues**
4120	**Emergency Medical Services Authority—Selected Issues**
4260	**Department of Health Services-Selected Issues**

PLEASE NOTE: **Please refer to the Senate Daily File for the dates and times of future Subcommittee hearings, including May Revision, regarding these departments.**

I. 2400 Department of Managed Care & Office of Patient Advocate

A. BACKGROUND

Purpose and Description of the Department

The purpose of the Department of Managed Health Care (DMHC) is to protect the public through administration and enforcement of laws regulating health care plans. The administration of these laws involves a variety of activities including licensing, examination, and responding to public inquiries and complaints. The program enforces its laws through administrative and civil action. Specifically, the DMHC licenses health care plans, conducts routine financial and medical surveys, and operates a consumer services toll-free complaint line.

The DMHC has three advisory boards--the Advisory Committee on Managed Care, the Clinical Advisory Board, and the Financial Standards Solvency Board. **In addition, the Office of the Patient Advocate located within the DMC will help ensure that the needs of managed care consumers are heard and met.**

Overall Budget of the Department

The budget proposes **total expenditures of $32.4 million (Managed Care Fund)** and 333 personnel-years for the DMHC, which includes $1.5 million for the Office of Patient Advocate. This reflects a net increase of $44,000 (Managed Care Fund) over the Budget Act of 2001.

Summary of Expenditures (dollars in thousands)	2001-02	2002-03	$ Change	% Change
Managed Care Fund	$32,407	$32,451	($44)	--
Total, Health Plan Program	$32,407	$32,451	($44)	--

B. ITEMS RECOMMENDED FOR CONSENT—Department of Managed Health Care

1. HMO Call/Help Center

Background: Through the HMO reform legislation, the DMHC was directed to develop a framework for the expedited resolution of grievances not resolved by the health plans and/or filed by consumers due to their dissatisfaction with their plan's response. As such, the HMO Call Center was restructured to meet legislative mandates and protect consumers through the resolution of their HMO grievances.

The HMO Help Center receives, reviews and researches complaints on behalf of enrollees. Many of these issues are complex and involve the expertise of legal counsel, health analysts, and medical professionals to reach resolution. Most offices within the DMHC access regulatory compliance and take action based on information gathered in the HMO Help Center. The HMO Help Center also assists in handling Independent Medical Reviews (IMR).

During the 2000-01 fiscal year, the HMO Help Center staff resolved over 4,600 written complaints and over 900 consumer concerns through the quick resolution process (i.e., does not require a written complaint). In addition, they addressed over 700 IMR requests. The HMO Help Center publishes an annual report which details the number and types of complaints they receive and resolve.

Governor's Proposed Budget: The budget **requests an increase of $850,000 (Managed Care Fund) to convert 14 limited-term positions to permanent and maintain existing staffing capacity for the HMO Call Center.** The DMHC states that establishing the 14 positions as permanent is essential to maintaining the current level of service for call, written complaint, and IMR volumes.

The DMHC has provided the Subcommittee with considerable data regarding justification of the positions, including workload data. As such, Subcommittee staff has raised no issues.

2. Office of Enforcement-- Caseload

Background: The Office of Enforcement within the DMHC is responsible for ensuring that the provisions of the Knox-Keene Act of 1975 are fully and regularly enforced. This responsibility includes all investigations and enforcement actions against health care service plans and others who violate the statute or regulatory provisions.

The Office of Enforcement receives complaints regarding health care service plan problems from the HMO Help Center, Licensing & Compliance, Medical Surveys, Financial Examination and Consumer Services sections, as well as the health care industry and media. **Upon receiving these cases, the Office of Enforcement conducts an extensive investigation. Based on this investigation, the Office of Enforcement determines whether to proceed to an enforcement action.**

A variety of enforcement actions may be pursued, including a Cease and Desist Order, an accusation seeking license revocation or imposition of an administrative penalty. A plan served with an administrative action may request an administrative hearing, which is comparable to a judicial bench trial. Other legal remedies are also available.

Governor's Proposed Budget: The **budget provides $447,000 (Managed Care Fund) to convert 7 limited-term positions to permanent in the Office of Enforcement in order to maintain existing capacity to resolve cases.**

These positions were provided in the Budget Act of 2000 on a limited-term basis to address a backlog of cases. However, the DMHC maintains that these positions are necessary in order to continue to address existing workload and additional cases. They contend that effective regulation requires effective, timely and fair enforcement actions, and as such, the need to maintain existing staffing levels.

Subcommittee staff was provided with detailed workload information and as such, has raised no issues.

C. ITEMS FOR DISCUSSION—Department of Managed Health Care

1. Expansion of the HMO Quality Report Card (Office of Patient Advocate)

Background—Office of Patient Advocate: The **Office of Patient Advocate (OPA) is an independent office** which is responsible for protecting patient rights. **Generally, the OPA is directed to:**

- **Assist patients who have complaints against their HMOs** or who need help in using the new Independent Review process;
- Develop educational guides for consumers on their health care rights and **to do public outreach and education**;
- Issue an annual HMO quality of care **report card**;
- Provide **recommendations to the DMC on enforcement actions to protect patients;**
- Identify ways to **improve services for consumers**; and
- Attend health fairs and other appropriate public gatherings to provide information.

Background—HMO Report Card: The report card is designed to inform HMO enrollees about quality of care, and is intended to assist in selecting a health care service plan. **The report card "grades" HMOs in five summary categories—**(1) staying healthy (prevention), (2) getting better, (3) living with illness, (4) doctor communication and service, and (5) health plan service. **The report card also provides health care service plans with comparative performance data to assist them in their quality improvement activities.**

The OPA has solicited views of interested parties, including a cultural and linguistic work group, on the critical issues that should be addressed in the report card. In addition, the Department of Managed Health Care's Advisory Committee on Managed Health Care is required to advise on the development of the annual report card and has provided numerous recommendations on expanding the scope of the report card.

Governor's Budget Request: The budget proposes **an increase of $500,000 (Managed Care Fund) in order to fully integrate medical group reporting, improve the reporting of quality indicators, add data on complaints and availability of linguistic services, print more copies of the report card and other related items.** This request would double the amount presently expended.

With respect to medical group reporting, the OPA intends to expand the capacity of the report card for comparing the performance of medical groups at the same level of detail as is possible with the health plans. Costs for this include the development of a final scoring methodology, development of the website display, and consumer testing.

The quality indicators will be more comprehensively evaluated (over 50 individual indicators) **and the criteria may be modified to include other data sets** in addition to

clinical data (i.e., HEDIS) and patient satisfaction data (i.e., CAHPS) that are currently used. Data regarding provider turnover rates, medical surveys and enforcement action and credentialing information will be evaluated along with other information.

The report card will be expanded to include information on cultural and linguistic data as well. Data will include information on whether the plan provides telephone interpretation services, access to face-to-face interpreters, lists of bilingual providers, written materials in different languages and other items. Designing an interactive website location for these data including translation of the site into Spanish, Chinese, Korean, and Tagalog is to be included.

Subcommittee Request and Question: The Subcommittee has requested the Office of Patient Advocate to respond to the following questions:

- **1.** Please provide a **brief overview** of the request.
- **2.** How have **consumers benefited** from the report card? What feedback has been obtained?

Budget Issue: Does the **Subcommittee want to approve the request?**

2. Financial Examinations of Specialized Plans

Background: The Knox-Keene Health Care Service Plan Act (the Act) requires that both health care plans ***and*** specialized health care service plans **(i.e., dental, vision, psychological, chiropractic, pharmacy)** regulated by the DMC must undergo a financial examination **as often as deemed necessary to protect the interest of enrollees, but at least once every five years.**

This is an important examination because the early detection of potential financial solvency issues results in the avoidance of disruption to the enrollees. Further, a plan with cash flow problems may not pay its providers in a timely manner which can jeopardize the cohesion of the provider network**. In addition, a financially weak plan may allow its health care decisions, such as referrals to specialists, to be influenced by the fiscal interests of the plan.**

Currently, there are **59 licensed specialized health plans** for which financial examinations are performed once every five years. **According to the DMHC based on a review of financial statements (March 31, 2001), twenty-seven of these plans were determined to be financially weak. They note that it is likely for many of these specialized health care service plans to continue to have financial viability problems.**

In the Budget Act of 2001, the DMHC was provided funding to conduct examinations once every three years for health care plans.

Governor's Proposed Budget: The budget **proposes an increase of $234,000 (Managed Care Fund) to fund 4 additional financial examiner positions which were**

being held vacant due to salary savings. These positions will be used to increase the frequency of financial examinations of specialized health plans from **once every five years to once every three years for those specialized health plans which *exhibit financial concerns.***

Subcommittee Request and Question: The Subcommittee has requested the DMHC to respond to the following questions:

- **1.** How will the DMHC **identify those plans** to be reviewed every three years?
- **2.** Specifically, **what follow up is done by the DMHC** when a plan exhibits fiscal problems?

Budget Issue: Does the Subcommittee want to approve or modify the request?

3. Specialized Health Plans—Clarification for Authority to Collect Assessments *(See Hand Out)*

Background: Existing statute **allows the DMHC to require plans to pay an annual assessment, *plus* a special assessment in any fiscal year from 2000-01 to 2002-03 to fund any portion of its budget not provided by the annual plan assessment.**

The annual assessment process funds about 60 percent of the department's budget. To provide the balance of funding for the budget, **the special assessment provision was added in 2000 to assist in funding new activities associated with the implementation of the new DMHC and the historic HMO reform legislation.** Further, it was deemed necessary to collect this special assessment for at least three fiscal years since many functions and activities were being phased-in and it was not fully known what volume of activity and work product would be required.

Finance Letter (Hand Out): The DMHC states that existing statute needs to be clarified with respect to the **special assessment process.**

Specifically, they contend that clarification is needed **regarding the Legislature's intent in establishing the process for the three-year special assessment and the notification to the plans that is required.** Currently the existing language at issue states that:

> **"**The director by notice to all licensed plans on or before **September 15, 2000** may require health care service plans to pay an additional assessment to provide the department with sufficient revenues to support costs and expenses as set forth in this section and subdivision (b) of Section 1341.4 for the 2000-01, 2001-02 and 20002-03 fiscal years.**"**

The DMHC wants to modify the statute to (1) clarify that the plans would be notified each year, and not by 2000, and **(2)** require plans who have not paid their special assessment to do so. **According to the DMHC, one plan has not paid their special assessment for 2001-02 or 2002-03 and owes the state over $912,000.**

The DMHC notes that the amount to be assessed each year can only be determined after the final budget is adopted. **Therefore, they are maintain that the intent of the Legislature was to provide the authority to the department to notify plans by September 15 of each year (i.e., 2000, 2001, and 2002).**

Budget Issue: Does the **Subcommittee want to adopt the proposed trailer bill language to clarify the statute regarding the notification of the special assessment and the payment of the assessment?**

4. Financial Solvency Standards Board

Background: SB 260 (Speier), Statutes of 1999, created the Financial Solvency Standards Board (Board). Generally, the Board is to develop and recommend financial solvency requirements and standards relating to plan operations and transactions, plan-provider contractual relationships and provider-affiliate operations and transactions. In addition, the Board advises the Director of the DMHC on matters of financial solvency that affect the delivery of health care services.

The Board is required to meet monthly during its first two years and then quarterly thereafter. Since August 2000, the 8-member Board has convened on a monthly basis, with all meetings being open to the public.

Summary of Court Ruling Regarding SB 260: The California Medical Association (CMA) filed suit to enjoin the DMHC from implementing certain regulatory provisions crafted in response to SB 260 which provided for the public disclosure of specific financial information. **In February 2002, a Superior Court ruling found**, among other things, that certain sections of Health and Safety Code were invalid and consequently, issued an injunction prohibiting the DMHC from collecting financial data regarding risk-bearing organizations, such as medical groups and independent practice associations (IPAs). In response to this ruling, the DMHC has stopped collecting this information and has disabled a web site which was used for this purpose.

It should be noted that the balance of SB 260's regulations remain in effect. For example, health plans are still required to submit basic information to the DMHC, and health plans are still required to provide enrollment and utilization information to their contracting risk-bearing provider organizations.

Governor's Proposed Budget: The department **requests an increase of $210,000 (Managed Care Fund) to convert 3 limited-term positions to permanent** to support the Financial Solvency Standards Board. The positions are: Corporate Counsel, Associate Governmental Program Analyst and Senior Typist.

The DMHC states that these positions are needed to continue program development (i.e., review/ grading and corrective plan process) and monitor and analyze reported data. For example, there have been a number of medical groups that have either filed bankruptcy or ceased their business operations, plus a number of other disruptive situations related to

the financial stress of a provider group. The department also fields calls from physicians and other providers regarding non-payment or related financial concerns. **As such, the Board's staff needs to be responsive to these provider solvency issues as they have a direct affect on patient care.**

Subcommittee Request and Questions: The Subcommittee has requested the DMHC to respond to the following questions:

- **1. Are other changes anticipated given the Superior Court ruling?**
- **2.** Please provide a brief description of the budget request.

Budget Issue: Does the Subcommittee want to approve or modify the request?

II. Health and Human Services Agency

A. BACKGROUND

Purpose and Description of the Department

The California Health and Human Services Agency (CHHS) administers the state's health, social services, rehabilitative and employment programs. The Secretary of the CHHS advises the Governor on major policy and program matters and oversees the operation of the agency departments. The purview of the CHHS includes the departments of Aging, Alcohol and Drugs, Community Services and Development, Developmental Services, Health Services, Mental Health, Rehabilitation, Social Services, and Employment Development, the Health and Human Services Data Center, the Office of Statewide Health Planning and Development, and the Managed Risk Medical Insurance Board, and the Emergency Medical Services Authority.

Through the Budget Act of 2001 and SB 456 (Speier), Statutes of 2001, the Office of Health Insurance Portability & Accountability Act (HIPAA) Implementation was created. This office resides within the CHHS.

The Office of HIPAA Implementation has statewide responsibility for the implementation of the federal HIPAA. The portion of HIPAA dealing with administrative simplification requires all billing and other electronic data transmissions to be standardized, as well as establishing new standards for the confidentially and security of this information. The office was established to direct and monitor this process.

Overall Budget of the Department

The budget proposes expenditures of **almost $5.2 million ($3.5 million General Fund) and 33 positions for the entire agency. Of this amount, $2.6 million and 11 positions are for the Office of HIPAA Implementation.**

B. ITEMS RECOMMENDED FOR CONSENT--Health and Human Services Agency

1. 15 Percent General Fund Reduction

Background and Governor's Proposed Budget: Due to the fiscal situation, the Agency was directed to reduce their General Fund budget by 15 percent, or $180,000. **To this end, the budget proposes elimination of two positions—Assistant Secretary and Staff Services Manager I—and $180,000.**

Subcommittee staff has raised no issues.

C. ISSUES FOR DISCUSSION—Health and Human Services Agency

1. Status Update on the Long Term Care Planning Council

Background—The Long Term Care Planning Council: AB 452 (Mazonni), Statutes of 1999, created the Long Term Care Planning Council (Council) within the Health and Human Services Agency to:

- Promote coordinated planning and policy development;
- Develop strategies to improve the quality and accessibility of consumer information;
- Review and make recommendations on ***all*** **LTC care budget changes being proposed by departments participating in the Council**;
- Design strategies to better monitor consumer responsiveness of services;
- **Develop strategies to streamline the regulation process** for LTC programs and services;
- Establish priorities and timelines for carrying out the Council's duties; and
- **Report annually**, beginning as of January 2001, to the Legislature on the Council's progress to date. (The **January 2002 report was just released** on Wednesday, April 17, 2002.)

The Council has been assigned the "central role" by the Health and Human Services Agency for Olmstead planning and implementation in California.

Background—Council's Workgroup Activities and Structure (Hand Out): In 2000, the Council **established five workgroups which are designed to be responsive to the Councils' key goals. These workgroups include the following:**

- Consumer Information;
- Long-Term Care Data
- Coordinating Community Long-Term Care Services;
- Nursing Facility Assessment and Transition Pilot;
- Facility and Services Licensure

The CHHS Agency states that these workgroups included not only interdepartmental staff but **a broader group of stakeholders**, ranging from providers to consumer and advocacy group members as well.

In its January 31, 2002 meeting, the Council approved recommendations for workgroup activities and structure. (These are contained in the Subcommittee's Hand Out package.)

Background—Olmstead Decision: In the Olmstead decision the United States Supreme Court, among other things, ruled that **an individual with a disability has a right to live in a community setting so long as three conditions are met: (1)** the individual's treating physician determines that community placement is appropriate, **(2)** the individual does not oppose such placement, and **(3)** the placement can be reasonably

accommodated, taking into account the resources available to the state and the needs of others that are receiving state-supported disability services.

The Supreme Court indicated that **states could establish compliance** with Title II of the American with Disabilities Act (ADA) **if it demonstrates that it has: (1)** a comprehensive**, effective working plan** for placing qualified persons with disabilities in less restrictive settings, and **(2) a waiting list that moves at a reasonable pace** not controlled by the state's endeavors to keep its institutions fully populated.

The federal Department of Health and Human Services sent letters to each Governor urging states to create Olmstead implementation plans. In addition, the federal CMS and federal Office of Civil Rights also sent a joint letter to state Medicaid (Medi-Cal) Directors providing guidance in the creation of such a plan.

Constituency Concerns—Olmstead planning: Several constituency groups are concerned with the states' planning process for implementing Olmstead. They note it has been three years since the decision was issued, yet **California has no plan** for Olmstead implementation. **As such, they are urging the state to develop a comprehensive plan which takes into consideration at a minimum, the following key elements:**

- Participation of key **stakeholders** in the development of a plan;
- **Development of a needs assessment** process so that there are goals for conducting individual assessments (including individuals in institutions as well as those at risk of institutionalization) to determine how community living would be possible/maintained;
- **Development of an infrastructure for new community services and supports** to ensure the availability of community integrated services;
- Outline of transition services to prepare individuals for a change in placement;
- **Framework for quality assurance and quality enhancement** of services;
- Comprehensive data collection which is individualized and tied to consumer outcomes;
- **Measurable goals** to be accomplished by certain dates; and
- **Proposals regarding the development of funding resources.**

Subcommittee Request and Questions: The Subcommittee has requested the Agency to respond to the following questions regarding the Council and its activities:

- **1. What specific progress has been made** by the Council regarding the key elements of the enabling legislation?
- **2.** What are the **Council's key items to be accomplished in the budget year?**
- **3. Please provide an update on the Council's activities related to the Olmstead decision. What is planning for the budget year?**

2. Health Insurance Portability & Accountability Act (HIPPA) *(See Hand Outs)*

Background--HIPAA: In 1996, President Clinton signed the HIPAA (Kennedy and Kassenbaum). HIPAA is designed to improve the availability of health insurance to working families and their children. **It also requires (1) administrative simplification, (2) revised security procedures, and (3) fraud control.**

In essence, all health-related organizations/providers/clearinghouses that electronically maintains or transmits health information pertaining to an individual are **required to comply with the HIPAA standards within two years of their adoption.**

Among these standards are:

- **Security and privacy standards** for health information.
- **Code sets and classification system** for the data elements of the transactions identified, including **all clinical diagnostic services**, procedures and treatments.
- **Electronic transactions and data elements for health claims** and equivalent encounter information, claims attachments, health care payment and remittance advice, health plan eligibility, enrollment and disenrollment, referral certification and authorization, and coordination of benefits.
- **Unique identifiers for individuals, employers, health plans, and health care providers** for use in the health care system.

Federal Rulemaking (Hand Out): The **federal Department of Health and Human Services (DHHS) is responsible for implementing the "administrative simplification" requirements through notice and comment rulemaking procedures**. Congress has 60-days after DHHS publishes a final rule to make any changes. After that, the health care industry, including all state health care programs, will have **two years to comply** with the final rules. **Failure to comply with HIPAA standards can result in significant monetary penalties.**

Note about "Local Codes": California uses about **6,000 local codes. The following is a list of some key ones:** alcohol and drug abuse treatment, case management, day treatment, community service program, crisis intervention, dialysis, durable medical equipment, EPSDT services, home health, FQHC and Rural Health Center clinic services, hospital services, lab services, nursing services, vaccines and immunizations, Waiver programs , many dental services, Family PACT, mental health services, nursing home services, transportation, personal care and respiratory care services, hospice, and physical, occupational and speech therapy.

Specific medical and payment policy will need to be extensively reviewed to determine the impact of consolidating and standardizing these local codes. As noted by the DHS, there are extensive issues here regarding medical and payment policy implications, rate of payment and special programs scope-of-service definitions.

It should be noted that President Bush signed recent legislation which provides for a one-year extension *(to October 16, 2003)* of the HIPAA compliance deadline for Transactions and Codes sets.

Background—Office of HIPAA Implementation (OHI): SB 456, Statutes of 2001, created a statutory framework for implementation of HIPAA, including the establishment of OHI within the Health and Human Services Agency**. OHI will serve as the lead entity for that state's activities, including policy formulation, direction, oversight, and coordination.** Additionally, OHI will work with county and city organizations to ensure coordination, although it does not have oversight responsibilities for these entities.

OHI has identified five phases that comprise HIPAA compliance. These phases include (1) project initiation, (2) initial assessment, (3) project plan, (4) detailed assessment, and (5) remediation. Each phase consists of several projects.

Governor's Revised 2001-02 Budget: The Budget Act of 2001 and SB 445 (Speier), Statutes of 2001, combined to appropriate $92.3 million ($24.3 million General Fund) to six state entities for HIPAA compliance activities. However, due to the state's fiscal constraints, SB 1xxx (Peace), Statutes of 2002, reduced this funding level. Specifically, General Fund support **was reduced by $19 million**, **for total current year expenditures of $18.2 million ($5.3 million General Fund).**

Governor's Proposed Budget for 2002-03: The **budget includes the *restoration* of all HIPAA funding in 2002-03 to the 2001-02 appropriation levels**, as shown below:

Department	Positions	Revised 2001-02	Proposed 2002-03	Proposed General Fund Increase
Office of HIPAA Implementation	12	$2 million **($1.6 million GF)**	$2.6 million **($2.1 million GF)**	**$469,000**
Health Services	22	$15.1 million **($3.2 million GF)**	$78.6 million **($16.8 million GF)**	**$13.5 million**
Mental Health	9	$171,000 **($56,000 GF)**	$2.4 million **($1.2 million GF)**	**$1.2 million**
Developmental Services	3	$118,000 **($59,000 GF)**	$2.5 million **($1.3 million GF)**	**$1.2 million**
Alcohol & Drug	5	$714,000 **($347,000 GF)**	$6 million **($3 million GF)**	**$2.7 million**
OSHDP	1	$99,000 (no GF)	$99,000 (no GF)	---
TOTALS	**52**	**$18.2 million ($5.3 million GF)**	**$92.3 million ($24.3 million GF)**	**$19 million Increase**

(Note: The Subcommittee will review each of these departments individually, as needed.)

Subcommittee Request and Questions:

- **1.** Please provide a **brief update** as to the status of HIPAA implementation for the state.
- **2.** What are the **key products to be produced in the budget year?**
- **3.** Please provide **a brief overview of the Agency's Office of HIPPA Implementation budget.**

Budget Issue: Does the Subcommittee **want to approve the budget for the Office of HIPAA Implementation (i.e., $2.6 million), pending receipt of the May Revision?**

3. Update on SB 480 Process—the "Health Care Options Project" *(Informational Only) (See Hand Outs)*

Background: SB 480 (Solis), Statutes of 1999, requires the Secretary of the CHHS Agency **to report to the Legislature concerning options for achieving universal health care coverage and establishing a process to develop these options.** SB 480 also calls on the Secretary to examine **and utilize research results from the study performed by the University of California (i.e., Universal Health Care Technical Advisory Committee-- UHCTAC)** conducted pursuant to the criteria in Senate Concurrent Resolution 100 of the 1997-98 Session of the Legislature.

Budget Acts of 2000 and 2001: Through the leadership of the Senate, an increase of $200,000 (General Fund) was sustained by the Governor in the Budget Act of 2000 to begin to meet the requirements of SB 480. In February 2001, the state was **awarded a HRSA grant of $1.2 million (federal funds) to continue development.** These moneys are currently being used to complete the project activities.

Overview of HCOP: The Health Care Options Project (HCOP) has **four main components as follows:**

- ***Existing Data and Research:*** A comprehensive summary of existing data and research has been completed and has been made available for analytic efforts. In total, six background papers on health care in California were prepared.
- ***Development of Nine Coverage Options:*** The CHHS Agency used a competitive process to solicit proposals for a broad range of coverage options. A total of nine coverage options papers by health care policy experts were selected for development**. The final options papers are to be available on the HCOP website by May 1, 2002. An extensive public meeting was held on April 12th in the Capitol to thoroughly discuss the options.**
- ***Quantitative and Qualitative Analyses (See Hand Out):*** The Lewin Group was selected to analyze and compare the quantitative aspects of the nine options papers. They used a micro-simulation model to measure the impact each option would have

on health care coverage and costs to the government, employers, individuals, and other affected entities.

In addition, **AZA Consulting** will be conducting a "cross-options paper" analysis to measure other factors, such as issues pertaining to quality, access and safety net impacts.

- ***Statewide Symposia:*** At the request of the CHHS Agency, the California Research Bureau convened four statewide symposia to seek public input on the nine options papers. These were held in Fresno, Sacramento, Oakland and Manhattan Beach.

Subcommittee Request and Questions:

- **1. Please provide a brief description of the process used for the project.**
- **2. Please provide an update** on the nine coverage options and the quantitative and qualitative analyses conducted for each.
- **3.** What **key objectives for the project overall still need to be completed?**
- **4. Please provide an update on the timeline for the project, including when the final reports to the Legislature and HRSA will be available.**

III. 4120 Emergency Medical Services Authority

A. BACKGROUND

Purpose and Description of the Department

The overall responsibilities and goals of the Emergency Medical Services Authority (EMSA) are to (1) assess statewide needs, effectiveness, and coordination of emergency medical service systems; **(2)** review and approve local emergency medical service plans; **(3)** coordinate medical and hospital disaster preparedness and response; **(4)** establish standards for the education, training and licensing of specified emergency medical care personnel; **(5)** establish standards for designating and monitoring poison control centers; **(6)** license paramedics and conduct disciplinary investigations as necessary; **(7)** develop standards for pediatric first aid and CPR training programs for child care providers; and **(8)** develop standards for emergency medical dispatcher training for the "911" emergency telephone system.

The budget proposes expenditures of $14.4 million ($8.7 million General Fund) which reflects a reduction of $26 million as compared to the revised current-year appropriation.

Overall Budget of the Department

The budget proposes expenditures of $14.4 million ($8.7 million General Fund) which reflects a reduction of $26 million as compared to the revised current-year appropriation.

Summary of Expenditures (dollars in thousands)	2001-02	2002-03	$ Change	% Change
General Fund	$33,987	$8,739	($25,248)	(74.3)
Federal Funds	$3,615	$3,306	($309)	(8.5)
Other Funds	$2,850	$2,390	($460)	(16.1)

B. ITEMS RECOMMENDED FOR CONSENT-Emergency Medical Services Authority

1. First There, First Care—Bystander Care for the Injured

Background and Finance Letter: The federal National Highway Traffic Safety Administration and the Health Resources and Services Administration developed the "First There, First Care—Bystander Care for the Injured Training Program for implementation in each state. The purpose of the program is to give motorists the information, training and confidence they need to provide life-saving bystander care at the scene of a crash, increasing the chances of survival for crash victims.

The EMSA was awarded a grant in the amount of $180,926 to conduct a 27-month (September 1, 2001 to December 31, 2003) project in high schools. **Under the proposal,**

the EMSA contracts with a paramedic to provide training at about 54 schools in 11 rural counties for young drivers 16 to 18 year olds. An evaluation will be conducted after the sessions end to determine if students used their training, and if they believe the training facilitated them in being safer drivers.

The EMSA is requesting **an increase of $82,000** (Reimbursements from the Office of Traffic Safety) **to fund 80 percent of a Health Program Specialist I position to serve as project coordinator for the extent of the grant period.** The responsibilities for this position will include all areas of school recruitment and scheduling, media coordination, training, purchasing, assembling and distributing first aid kits and materials, course monitoring and evaluations, and required federal reports and conference presentations.

Subcommittee staff raised no issues.

2. Consolidated Reduction—Fund Shift and General Fund Reduction

Background and Governor's Proposed Budget: The EMSA is requesting a series of adjustments due to the difficult fiscal situation.

First, they are proposing a reduction of $107,000 and one position by eliminating the Planning and Development unit as a separate function within the department. Second, it is proposed to spread over all department funds certain administrative costs that had originally been solely borne by the General Fund.

These adjustments will reduce General Fund support by $248,000, and increase expenditures from two special funds—EMS Training Program Approval Fund ($48,000 increase) and EMS Personnel Fund ($93,000) for net savings of $107,000 (total funds).

Subcommittee staff has raised no issues.

C. ITEMS FOR DISCUSSION—Emergency Medical Services Authority

1. Statewide EMS Evaluation & Planning Project

Background: There are **32 local Emergency Medical Services (EMS) agencies** within the state with many diverse problems. The delivery of emergency health care requires the participation of numerous independent individuals and organizations, including public safety agencies, ambulance services, physicians, and hospitals.

The state's Emergency Medical Services Administration (EMSA) contends that these multiple, autonomous organizations have high degrees of functional interdependence as they work to provide care, sometimes simultaneously, to individual patients. As such, managing this interdependence requires planning, standardization, and mutual adjustment. **The EMSA states that the lack of a statewide plan frequently results in conflicts among providers, inefficiencies, and a lower level of care to the patient.**

Through a public process, the EMSA developed goals, contained in their **"Vision for the Future of EMS in California",** for achieving a statewide plan. **One particular recommendation that came forth was the need to develop a process for the periodic review and assessment of local EMS systems. This assessment has been completed and recommendations from it have been assigned to different committees for the development of implementation strategies.**

Finance Letter: The EMSA **is requesting an increase of $171,000 (Reimbursements from the state Office of Traffic Safety which received a federal grant) and 2 positions—Associate Health Program Advisor and Office Assistant--** to continue work on the state's development of California's first statewide EMS Plan, the revision of California's EMS System Standards and Guidelines, and to provide assistance to several committees who are crafting implementation strategies as contained in the local EMS systems assessment.

They contend that the ultimate goal of the plan is to improve the overall quality of care for the EMS patient, and that state oversight and enforcement will become more effective as local EMS agencies will be required to meet statewide standards.

2. California Emergency Medical Services Information System (CEMSIS)

Background: Through the federal National Highway Traffic Safety Administration, an assessment of EMS in California was completed. **One of the conclusions of this assessment was that an automated EMS information system should be implemented**.

Funding was obtained from the Office of Traffic Safety to begin to create the statewide database. A Feasibility Study Report (FSR) was approved and a Request for Application (RFP) was issued. Initiated in January 2000, the project is scheduled to be **completed in December 2002**.

Specifically, the database will contain EMS-based patient information, quality improvement data, and related items. **The intent of this effort is to coordinate and match data from several different sources, including OSHPD, CDFF and the CHP, to assist state and local EMS administrators in program decision-making, including making changes to patient care, dispatch and transport, and EMS training.** Currently, data related to prehospital care is being gathered and used at the local level, but there is only limited ability to associate the eventual patient outcome with the care that is given by field EMS personnel.

Finance Letter: The EMSA is requesting **an increase of $206,000 (Reimbursements from the Office of Traffic Safety) to fund half of an Associate Information Systems Analyst position (one limited-term position for 6 months) and several small contracts, including $133,000 for** software development, to implement a statewide data system.

Subcommittee Request and Questions: The Subcommittee has requested the EMSA to respond to the following questions:

- **1.** Please provide **a brief summary** of the request and how the data system will function.
- **2. How will patient medical privacy, security and confidentiality requirements be maintained?**

Budget Issue: Does the Subcommittee want to approve or modify the proposal?

3. Emergency Medical Services to Children (EMSC)—Constituency Request

Background: Historically, EMS systems have primarily focused on the assessment, care and treatment of adults and have **not addressed the special needs of children.** Even though considerable work has been conducted over the past few years, the EMSA notes that **there is still not consistent application of standardized care in California for emergency medical services to children.** Children have unique problems and needs associated with acute injury and illness, and suffer from different types of injuries and illnesses than adults. **As a result, children require different types of diagnostic procedures, medication, and support techniques.**

Legislative History: Through a small federal grant the EMSA began to develop an **Emergency Medical Services for Children (EMSC) Model.** From the beginning, the major goal of the project has been development and implementation of EMSC within local or regional EMS agencies. EMSC represents a linked "continuum of care", intended to integrate community pediatric emergency and critical care delivered in many various settings by many different care providers.

The continuum includes both clinical and operational components. The clinical components are: prevention, prehospital personnel education, pediatric basic life support and advanced life support equipment, prehospital treatment protocols, emergency department organization and equipment, pediatrics within general trauma centers, interfacility consultation and transfer, pediatric critical care centers, pediatric trauma centers, and pediatric rehabilitation. **The operational components are:** system planing, implementation and management, and information management.

The EMSA organized 14 different multidisciplinary subcommittees to address and describe, through guidelines or recommendations, each of the different EMSC clinical and operational components.

The federal grant funds expired in 1996. In 1996, SB 1664 (Thompson), was introduced to expand on the EMSC Model. (This bill was subsequently subsumed in AB 3483, the omnibus health trailer bill for 1996).

AB 3483, Statutes of 1996, required the EMS Authority to:

- Provide advice and technical assistance to local EMS agencies on the integration of emergency medical services to children into their EMS system;
- Monitor the implementation of the system at the local level;
- Establish a Technical Advisory Committee; and
- Work with the DHS and other agencies to craft standards and policies for the delivery of emergency and critical care services to children.

Funding History: **The Budget Acts of 1996, 1998, and 2000 all provided 1.5 positions (limited-term) to conduct activities associated with the EMSC. However, in the Budget Act of 2001, two half-time positions were funded with federal Health Resources and Services Administration (HRSA) funding. The Governor's proposed budget for 2002-03 assumes no funding or positions for the program since federal funds are not available and there are General Fund fiscal constraints.**

Report to the Legislature on EMS for Children (August 2000): As required by the enabling legislation, the EMSA published a comprehensive report on the status of EMS for children activities. **Key products included:**

- Established an **EMSC Technical Advisory Committee** comprised of pediatric experts;
- Developed **a 5-year plan for California** which outlines specific EMSC needs along with action steps necessary to achieve the goals;
- Developed an **EMSC Model** that assisted in the development of standards and key products that make up the Model;
- Provided technical assistance and consultation visits to local EMS agencies for help in implementing the EMSC Model into their EMS system; and
- Convened three EMSC conferences to promote the implementation of EMSC.

According to the EMSA, twelve EMS agencies, consisting of eighteen counties still need to integrate part, or all of the EMSC Model in their EMS systems. Other critical needs, as recommended in the 5-year plan for California, also need to be addressed throughout the state.

Governor's Proposed Budget: **The Governor's proposed budget assumes no funding or positions for the program since federal funds are not available and there are General Fund fiscal constraints.**

Current Needs and Constituency Request: Several pediatric specialty groups, as well as other health care organizations, have expressed concern that there is now no EMSC coordinator at the state level. They content that the EMSC Technical Advisory Committee, consisting of 15 members that represent a broad constituency of EMSC constituency organizations, collectively donates over 1,3000 hours annually to improving EMSC, yet the state will not even provide staff assistance to facilitate enactment of recommendations and to accomplish goals as identified in the 5-year plan for California.

They believe the EMSC coordinator position was invaluable for it assisted counties with implementing EMSC, evaluated EMSC at the local level, updated EMSC guidelines, conducted activities associated with the 5-year plan, and provided staff support to the Technical Advisory Committee.

Budget Issue: Does the **Subcommittee want to provide a position and funding for this purpose?**

If so, Subcommittee staff would recommend **to provide an Associate Governmental Program Analyst position and funding of $70,000.** Further, Subcommittee staff is presently investigating the potential to utilize federal Maternal and Child Health block grant moneys for this purpose. This information will be available at the time of the May Revision.

IV. 4260 Department of Health Services—Selected Issues

ITEMS RECOMMENDED FOR CONSENT

1. Federal Funds for Long-Term Care Rate Study (AB 1731 & AB 1075)

Background and Proposed Finance Letter: The DHS is requesting an increase of $500,000 (federal funds) in order to fund a long-term care rate study as required by AB 1731, Statutes of 2000, and as amended by AB 1075, Statutes of 2001.

Total funding for the long-term care rate study will be $2 million. Of this amount, **(1)** $1 million (total funds) has been proposed for expenditure through the Governor's proposed budget, and was approved by the Subcommittee in its April 1 meeting, and **(2)** $500,000 (General Fund) was appropriated through the enabling legislation. The enabling legislation also provided for a federal match, if available. The DHS has now confirmed that such a match is available.

The Finance Letter is requesting an increase of $500,000 in federal funds to continue with the rate study.

Subcommittee staff has raised no issues with this request. Further, the Subcommittee discussed implementation activities related to AB 1075 in its April 1 hearing and did not raise any concerns with respect to the rate study.

2. State Fire Marshal Contract—Shift to DHS Licensing & Certification

Background and Finance Letter: Under an existing Memorandum Of Understanding (MOU) with the DHS, the State Fire Marshal conducts Fire and Life Safety Code surveys of health facilities as part of the process for certifying health facilities for participation in Medi-Cal and Medicare (in order to obtain federal matching funds). However, effective June 30, 2002, the State Fire Marshal is terminating this arrangement.

The Finance Letter is requesting to redirect 17 positions as currently established in the State Fire Marshal's budget to the DHS in order to continue to conduct Fire and Life Safety Code surveys of health facilities as required by federal law in order to obtain federal financial participation under Medi-Cal and Medicare. The same level of funding would be provided; as such, no fiscal change is necessary (i.e., the DHS was previously funding the MOU).

Subcommittee staff has raised no issues with this request.

3. Medical Waste Management Program—Special Fund Issue

Background and Finance Letter: The DHS' Environmental Management Branch is requesting **an increase of $100,000 (Medical Waste Management Program)** in order to

conduct enforcement activities regarding medical waste. These funds are being expended from existing reserves of $1.5 million. There is no effect on the General Fund.

Under this program, the DHS permits and inspects all medical waste off-site treatment facilities; medical waste transfer stations; approves all alternative treatment technologies and responds to emergency incidents. Additionally, the program serves as the local enforcement agency in 27 local health jurisdictions that elected to have the state implement the large quantity generator inspection program within their jurisdiction.

Subcommittee staff has raised no issues regarding this request.

4. Lead-Related Construction Program—Technical Adjustment

Background and Finance Letter: The Lead-Related Construction Program, established in 1993, **covers lead-related construction issues, such as accreditation of training providers and certification of individuals involved in lead-related construction. It assists California in meeting federal requirements to be eligible for receiving grant funds for lead hazard control** from the federal Housing and Urban Renewal Department (HUD) and the federal Environmental Protection Agency (EPA). Since inception of the Lead-Related Construction Program, state and local governments have received over $106 million from HUD.

The purpose of the program is to (1) nurture a private sector infrastructure to identify and eliminate environmental lead hazards, (2) develop a professional capacity within local health and environmental departments so that they can identify and eliminate environmental lead hazards, and (3) qualify eligible state and local agencies in California to receive grants from federal entities.

Finance Letter: During the development of the Governor's January budget, a technical error occurred and the DHS inadvertently charged certain baseline expenditures to a special fund in lieu of the General Fund. As such, a Finance Letter has been received to correct for this snafu. **The Finance Letter is requesting an increase of $853,000 (General Fund) and a reduction of $853,000 (Childhood Lead Poisoning Prevention Fund).**

Subcommittee staff has raised no issues with this request.

ITEMS FOR DISCUSSION

1. Status Update on Pending DHS Report—Other Gynecological Cancers

Background (See Hand Out): The Subcommittee crafted budget trailer bill legislation, as contained in AB 430, Statutes of 2001 (the omnibus health trailer), to address concerns regarding **noncervical gynecological cancers**, **including uterine and ovarian cancers**.

The language was crafted in response to the state's establishment of the federal Medicaid (Medi-Cal) option to provide breast and gynecological cancer treatment. Under this new state treatment program enacted as part of the Budget Act of 2001, **noncervical gynecological cancers were not included since the federal option did not recognize these diagnoses for federal financial participation.** During the 2001-02 budget deliberations, the DHS estimated that annualized costs of almost $19 million (General Fund) would be incurred if noncervical gynecological cancers were included. However, these figures were deemed to be preliminary and a more definitive analysis was determined to be needed.

In order to obtain more comprehensive information regarding the potential inclusion of these cancers under the program, language was crafted to require the DHS to report back to the Legislature **by March 31, 2002**. **Specifically the report was to address the following key items:**

- The extent to which low-income uninsured women with noncervical gynecological cancers are currently receiving medical treatment;
- Mechanisms by which access to treatment could be expanded under existing DHS programs, as well as programs administered by the MRMIB; and
- A comprehensive fiscal analysis by the DHS for expansion of treatment services to this group under the CA Breast and Gynecological Cancer Treatment Program.

Further, the language provided that **the Director of the DHS could consult with various representatives, including health care consumers, providers, insurers, health care workers, advocates, counties, and all other interested parties.**

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. Specifically, what has or will be done to ensure that constituency groups have been consulted** regarding the development and contents of the analyses and report?
- **2.** Can the analyses/report will shared in a draft format for discussion purposes with the constituency groups?
- **3.** Since the timeframe has already passed and more work needs to be conducted, **what revised timeframes are we looking at?**

Budget Issue: What **is being done to complete the requested analyses/report as directed by the Legislature?**

2. CA Birth Defects Monitoring Program—Proposed Reduction of $1.6 million

Background: In California, **one out of every 33 babies is born with a birth defect.** Birth defects are the leading cause of infant mortality. Birth defects can strike any family regardless of income, race or level of education. **They can occur even if there is no family history of birth defects, when the mother has good prenatal care or if the mother does not imbibe in alcohol or drugs.**

Research is vital to stopping birth defects before they occur and state surveillance programs have been a key component in the effort. The economic cost of birth defects is estimated to be over $1 billion annually.

The California Birth Defects Monitoring Program (CBDMP) was established in 1982. It is **jointly operated with the March of Dimes** and is a national and international leader in birth defects epidemiology. **The CBDMP is designated as one of eight national Centers of Excellence for Birth Defects Research and Prevention and is part of a nationwide effort to discover the causes of birth defects.**

The following lists recent highlights:

- Finding the first evidence associating urban air pollution with heart defects (2001);
- Identifying that women who take folic acid before becoming pregnant reduce the chance of having a baby born with spinal defects by up to 70 percent;
- Showing a link between obesity and increased spinal defects;
- Linking home pesticide use to several common birth defects (1999);
- Discovering stressful life events may increase the risk for birth defects (2000);
- Demonstrating gene-environment interaction showing babies with a particular gene are eight times more likely to have oral clefts if their mothers smoke (1998);
- Ruling out high voltage power lines as increases birth defects.

For the past 20 years, the CBDMP's contributions to the discovery of new risk factors and protective factors guide future clinical care and public health strategies for the prevention of birth defects.

Current Year Funding: Existing funding for **the DHS program is about $4.4 million ($4.1 million General Fund and $250,000 federal Maternal & Child Health block grant funds).** In addition, the **March of Dimes has successfully obtained** two federal grants which have a combined total of $2 million. Of this federal amount, $900,000 is set to expire in one year. Clearly, the CBDMP has leveraged the baseline state funding to obtain additional grant funds.

Governor's Proposed Budget: The budget proposes **a reduction of almost $1.6 million (General Fund) from the program. This proposal represents a 45 percent reduction of state funding.**

According to the DHS, in order to effectuate this reduction, they would need to make several programmatic adjustments. First, they would limit the CBDMP to

monitoring the four largest classes of birth defects (i.e., nervous system, clefts, heart and Downs Syndrome) occurring in Los Angeles, San Francisco, Santa Clara, and San Diego counties. Second, other overall activities would be scaled back significantly, including the following:

- **Fewer investigations into potential environmental causes of birth defects would be conducted;**
- **Less capacity to do research and clinical analysis;**
- **The birth defects registry will obtain less data; and**
- **They would be less competitive in attracting federal and other additional grant funds.**

Further, the DHS states that mental retardation data shall continue to be collected in San Diego County and in the Central Valley, but not in other areas of the state.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. Is the CBDMP a successful program that has shown results and achieved national status for its accomplishments?**
- **2. Please provide a *full description* of how the reduction will be implemented.**
- **3. Is the program being reduced solely due to the fiscal situation?**

Budget Issue: Are funds **available for the Subcommittee to restore all or a portion of this proposed reduction?**

3. Childhood Lead Poisoning Prevention (CLPP) Program

Background: According to a recent DHS report on Childhood Lead, **California is riddled with environmental lead contamination.** With 2.2 million pre-1950 housing units, California is third in the nation for number of old dwellings likely to contain lead based paint.

Children enrolled in the Medi-Cal, CHDP and Healthy Families Program (HFP) account for about 80 percent of the lead poisonings and constitute the high-risk group.

The negative effects of lead on children's health are well documented. **Lead poisoning can cause learning disabilities, behavioral problems and at very high levels, seizures, coma, and even death. In addition to nervous system effects, recent research has linked lead exposure to tooth decay in young children and to high blood pressure and kidney disease in adults.**

According to the DHS, **there are about 128,000 California children aged one to five years who have elevated blood lead levels, among them about 38,000 need comprehensive public and environmental health services.** Poor and disadvantaged children are at especially high risk.

For about the last eleven years, the DHS has been gradually building a comprehensive statewide public health effort to mitigate childhood lead poisoning. **However, constraints on program funding have hampered the ability of the DHS to put into place all program elements required to effectively and efficiently eliminate this disease.**

Background--Bureau of State Audits Reports: **In comprehensive audits conducted in 1999 and 2001 by the Bureau of State Audits (BSA), serious gaps in the DHS program were found.** For example, the report showed that despite a longstanding requirement to perform blood lead screening on all young enrollees, **it was found that only 10 percent of California children needing lead-related medical care and case management were being identified.**

Among many other things, the audits recommended for the DHS to:

- Adopt regulations requiring labs to report all blood-level test results.
- Adopt standard-of-care regulations as previously directed by the Legislature.
- Ensure that homeowners and property owners properly eliminate or reduce lead hazards.
- Take immediate action to identify and educate those providers participating in the Medi-Cal and CHDP Programs.
- Ensure local programs submit to the DHS all case management information outlining the services provided to lead-poisoned children.
- Monitor local program's activities to ensure lead-poisoned children receive appropriate care. (This should entail a high-level review of all follow-up reports to ensure their completeness and a more detailed assessment of the care given for a representative sample of cases.)
- Complete the training curriculum for eliminating or reducing lead hazards in California's school and day care facilities so that children do not remain at risk for lead poisoning.

Need for More Revenues and DHS Response to Audits (See Hand Outs): The DHS has documented that substantial changes have been made by the CLPP Program to correct deficiencies identified through the audits. **However, many key items still need to be addressed in order to fully correct the deficiencies noted. The DHS notes that correction of these deficiencies will require increased resources.**

Although the enabling legislation which established the CLPP Fund **specified a maximum collection of $16 million annually, *adjusted* for CPI and caseload**, fee collection was capped by the Administration at $12 million annually.

The Governor's proposed budget now assumes that the full fee collection will occur. As such, it is assumed that a total of $22 million will be collected (beginning as of January 1, 2002). Specifically, this assumes a baseline figure of $16 million multiplied by the adjustment factor. The adjustment factor is the compounded changes due to the CPI (since 1992), plus an adjustment for caseload compared to the base year, plus an adjustment for the changes in workload compared to the base year.

A portion of these additional resources are proposed to be used in the budget to proceed with additional corrective actions needed to meet both state and federal law with respect to childhood lead mitigation.

Governor's Proposed Budget: The budget proposes **an increase of $7.2 million (Childhood Lead Poisoning Prevention Fund)** to provide for a more comprehensive program and respond to concerns expressed by the Legislature and Bureau of State Audits. **Key items include funds to (1)** support the reporting and processing of increased blood lead test reports, **(2)** develop local and state enforcement of clean-up orders and site mitigation activities, and **(3)** conduct a field-test to study the prevalence of lead poisoning in California.

Specifically, the DHS is proposing to expend these requested funds as follows:

- **Use a total of $2.3 million to** (1) permanently establish 8 positions which are slated to expire as of June 30, 2002 ($500,000) and (2) provide for contract funds ($1.8 million) which are to be used for consultant staff. These staff resources will be used to conduct **a wide array of activities**, including analyzing technical data, meeting program mandates, implementing regulations, conducting various reporting and enforcement activities, and performing monitoring activities.
- **Provide $1.1 million for contracts** to support the reporting and processing of increased **blood lead test reports** that will result from new medical provider regulations for lead screening (as adopted in November 2001).
- **Dedicate $3 million** to support the development of local ($2.5 million) and state ($500,000) enforcement of clean up orders to assure lead-safe environments, including removal of lead hazards associated with lead poisoned children, as well as hazards that put children at risk for lead poisoning.
- **Provide $200,000** on a one-time only basis **to design and field-test a study of the prevalence of lead poisoning in California.**
- **Appropriate $400,000** on a one-time only basis to design and filed-test a study to evaluate the cost effectiveness of outreach by community-based organizations and of neighborhood based screening to increase case finding in difficult to reach communities.
- **Provide $200,000** for various operating expenses and equipment associated with the permanent positions and various activities.

The Administration is also proceeding with policy legislation which, among other things, will **(1)** require laboratories to report all lead values, **(2)** require electronic

reporting of lead values by laboratories by January 1, 2005, **(3)** provide state and local agencies with the authority to enforce clean-up orders, **(4)** provide these same agencies authority to enforce work practice standards during the conduct of clean-up activities, and **(5)** provides for enforcement of standards for training and certification of individuals conducting clean-up orders.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please describe **the key corrective actions that will be completed** and/or implemented in the budget year.
- **2.** How and when will the **local funds be allocated** by the DHS?
- **3.** How will **program outcome indicators and accountability** be measured and assured?

Budget Issue: Does the Subcommittee want to approve or modify the request?

4. California Children Services Program—Update on the CMS Net Project

Background--CCS: The California Children's Services (CCS) Program provides medical diagnosis, case management, treatment and therapy to financially eligible children **with specific medical conditions**, **including birth defects, chronic illness, genetic diseases and injuries due to accidents or violence**. It is the oldest managed health care program in the state and the only one focused specifically on children with special health care needs. **By law, CCS services are provided as a separate and distinct medical treatment (i.e., carved-out service).**

CCS is joint operated by the counties and the state. As such, County Realignment funds, state General Fund support, and federal funds (when applicable) are used to support the program.

Background—EDS Billing and Commencement of the Initial CMS Net Project:
Chapter 1210, **Statutes of 1994** (AB 2793, B. Friedman) required the DHS to establish a centralized CCS Program billing system and required that ***all*** counties submit claims for reimbursement of CCS to the **state fiscal intermediary—Electronic Data Systems (EDS)—by no later than January 1999.** The statute further states that **(1)** the DHS shall work with the counties to develop a schedule for the counties to begin submitting claims to the state, and **(2)** if a DHS review of the system determines that as **of January 1, 2000**, any county has incurred increased costs as a result of submitting claims through EDS, **then that county is exempt from the statute's requirement.**

This legislation lead to an overall project—the Children's Medical Services (CMS) Net Project. Since this time, the project has undergone several phases. The intent of the project has always been to craft a centralized billing system for the CCS and

then later, Genetically Handicapped Persons Program (GHPP) to **(1)** improve efficiencies and economies of scale in processing claims, **(2)** ensure a consistent application of state CCS policies for coverage of services and provider reimbursements, and **(3)** capture federal funding opportunities (via Medi-Cal and Healthy Families) and third party billing opportunities.

Overview and Purpose of CMS Net/Enhancement Project: CMS Net is an automated case management system for CCS currently used by 49 counties and three CMS Branch regional offices. **Nine other counties use other automated or manual systems. Several of these counties, including Los Angeles, which has *over one third of the state CCS caseload*, plan to convert to the state's CMS Net System.**

The CMS Net Project **links with other statewide databases**, including the Medi-Cal Eligibility Data System and the Statewide Client Index and merges client eligibility and claims processing automation with those established with EDS**. This linkage between databases creates the ability to better identify and serve clients, particularly those enrolled in multiple programs, and providers.**

The project has several phases ("enhancements") including the following:

- CCS Eligibility Phases I and II
- CCS Service Authorizations
- Provider Enrollment
- GHPP Eligibility
- GHPP Service Authorizations
- CMS Net Reporting
- CMS Net Full Screen Conversion

According to the DHS, it is expected that the CMS Net Project, including all "enhancements", will result in savings of $22.3 million annually at full implementation.. These savings are to be achieved by eliminating inefficiencies in the current manual claims review and cost recovery processes and by redirecting staff responsible for claims review to eligibility management and inpatient nurse case management activities.

In addition, the CMS Net Project will make it possible to obtain General Fund savings by maximizing federal Medicaid (Medi-Cal) and S-CHIP (Healthy Families Program) participation in the CCS Program. Further, the system will greatly improve the state's ability to identify other third party health insurance that can be billed prior to billing the CCS Program.

Checkered History of CMS Net Enhancement Project: The CMS Net Enhancement Project was funded effective January 1, 1998 **and was originally planned for completion in September 2001. However, due to delays within the Administration, proposed project changes and the resignation of the original development contractor, the project has been delayed.**

Unfortunately, it has an entwined history of reports, as well as starts and stops as noted below:

- The Feasibility Study Report (FSR) for CMS Net was completed in **December 1995** and approved in January 1997;
- A Special Project Report (SPR) was submitted September 1997 and approved by the Department of Information Technology (DOIT) and the Technology Investment Review Unit (TIRU) in December 1997.
- A second SPR was submitted in April 1998 and approved in September 1998.
- A third SPR was submitted October 1999 and approved in April 2000; **and**
- **A fourth SPR was submitted December 2001.**

In a June 2001 report, the Bureau of State Audits identified considerable project management deficiencies with the CMS Net project. As such, the DHS has contracted for a full-time project manager to oversee activities related to cost, schedule, risk, communication, resources and procurement.

Constituency Concerns: The **CCS provider community is demanding that the DHS improve the efficiency of CCS claims processing.** Many have threatened to leave the CCS Program and others already refuse to see additional CCS clients because of claims adjudication inefficiencies and delays. Without qualified providers, the effectiveness of the CCS program is in jeopardy. CCS clients will be at risk of not receiving necessary medical services.

County Conversions: **Conversion of a county to CMS Net requires extensive work,** including the following: **(1)** establishing connectivity between the CCS county office and the state's Health and Human Services Data Center, **(2)** planning for the change in CCS operations associated with use of CMS Net; **(3)** configuring and testing the county CCS data files so they can be process through the CMS net data conversion files; **(4)** training county CCS staff in the use of CMS Net; and **(5)** scheduling a date when conversion takes place.

Experience has shown that county readiness to convert is critical to the pace at which it occurs.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to provide **a detailed update as the progress of implementing the CMS Net/Enhancement and EDS billing**, and to respond to the following questions:

- **1. Using the CMS Net progress chart (Hand Out),** please provide **a brief overview of the key milestones to be completed in the budget year, including any Request for Applications/Proposals to be sent out**.
- **2.** What are the **estimated completion dates for the following phases** of the CMS Net Project?
  - **A.** Electronic transmittal of the CCS authorization of services to the state fiscal intermediary (i.e., EDS);
  - **B.** Sending provider **claims directly to the fiscal intermediary** rather than sending them first to the CCS office that authorized the service (This

part of the system when implemented will save considerable time and eliminate confusion on the status and location of the claim.);

- **3.** When will **the following counties be automated with CMS Net** and what is the **DHS doing to ensure these counties convert?** (Los Angeles, Sonoma, Sacramento, Alameda, Contra Costa, Orange, San Diego, San Francisco, and San Mateo)

5. Genetically Handicapped Persons Program (GHPP)—Baseline Budget Adjustments & LAO Option

Background: The GHPP **provides diagnostic evaluations, treatment services, and medical case management services for adults with certain genetic diseases**, including cystic fibrosis, hemophilia, sickle cell disease, Huntington's disease, and certain neurological metabolic diseases.

Background—Hemophilia and Its Treatment: Generally, patients with hemophilia refers to a group of bleeding disorders, most commonly "factor 8" and "factor 9" deficiencies but also include von Willebrands Disease and other "factors". Patients with these disorders are classified based on their level of procoagulant that is deficient. Disease management through comprehensive hemophilia treatment centers is often recommended.

Individuals with these disorders require treatment **with factor concentrates for bleeding episodes. These factor concentrates are medications that are either made through purification of plasma proteins or through a process of genetic engineering. These products are clinically complex and cannot be considered interchangeable. Prescriptions are usually written as brand name prescriptions after discussion of the particular product between patient and caregiver.**

Governor's Proposed Budget: **The budget proposes expenditures of $35.9 million ($35.7 million General Fund, and $150,000 enrollment fees)** to provide treatment assistance to **about 892 average annual participants (an average annual cost of $40,233 per case)**. This reflects an increase of $1.5 million (General Fund) over the revised current year budget. **The proposal is consistent with existing policies, and reflects modest adjustments for caseload and utilization.**

Based on information provided by the DHS, the following displays proposed expenditures by GHPP eligibility/diagnosis:

- Hemophilia $29.9 million
- Cystic Fibrosis $4.8 million
- Sickle Cell $688,000
- Huntington's $400,000
- Metabolic $77,000

Legislative Analyst's Office "Option": In an effort to provide the Legislation with "options" for curtailing and reducing General Fund expenditures due to the current fiscal situation, the LAO has crafted an "Options Report" which contains various proposals to reduce General Fund expenditures.

One of the proposed options would be to have GHPP contract out for blood products. **The LAO contends that the state may be able to purchase products at a lower cost by establishing a competitive bidding process** instead of the individual client based purchasing procedure that is currently used.

The LAO also states that GHPP may not be identifying all cases in which program costs could be reimbursed by third-party private insurance and may not be assessing collecting the maximum amount of revenue it can from client contributions.

No exact dollar savings were identified by the LAO, though they say there is potentially several million dollars in annual General Fund savings.

Subcommittee Request and Questions: The Subcommittee has requested the DHS and the LAO to respond to the following questions:

- **1. DHS, Generally, what has been the recent fiscal history of the program?**
- **2. DHS,** Does **GHPP currently obtain rebates for the various blood products and medications it supplies under the program** in the same manner and level as the Medi-Cal Program? May it be possible to obtain additional rebates (i.e., above the current GHPP level) for the program in the budget year?
- **3. LAO**, Please explain **your proposed "option"** for contracting.
- **4. DHS**, Do you have **any comments regarding the LAO "option"?**

Budget Issue: Does the **Subcommittee want to (1) adopt or modify the proposed budget, and (2) request any additional follow-up?**

6. Information Technology—Request for Staff

Background: The DHS states that they have been directed by the DOF, Department of Information Technology (DOIT), Technology Information Research Unit (TIRU), and the Bureau of State Audits to improve project and contract management practices with respect to information technology oversight, services and functions.

Governor's Budget Request: The budget is **requesting an increase of about $2 million ($790,000 General Fund,** $790,000 matching federal funds, and $395,000 in various special funds) to hire 8 contract staff to deploy critical information technology project management and oversight services and functions. These include:

- Implement the practices and policies needed to ensure successful IT project management;
- Meet the directives of DOIT and TIRU to build a DHS project management organization;
- Implement department-wide IT strategic planning that address business strategies;
- Provide IT project and acquisition oversight; and
- Provide project management methodologies, practices, processes and procedures.

The DHS states that the addition of contracted staff will reduce the risks to IT project initiation and deployment and help ensure IT projects are selected based on DHS business strategies, deployed using industry accepted best practices, correctly estimated, and managed within scope, budget, and schedule.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** How many staff does the DHS presently have who are responsible for Information Technology projects?
- **2.** Does the DHS currently operate a Project Management Office? How is this presently funded?
- **3.** Please provide **a brief summary of the budget request.**

Budget Issue: Are there sufficient General Fund resources to provide funding for this request?

(LAST PAGE OF AGENDA)